

**Memorandum**

Date OCT 27 1999

From June Gibbs Brown
Inspector General *June G Brown*

Subject Review of Fee-For-Service Payments for Selected Medicare Beneficiaries Enrolled in Managed Care Risk Plans (A-07-97-01247)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Fee-For-Service Payments for Selected Medicare Beneficiaries Enrolled in Managed Care Risk Plans." The objective of our audit was to determine if Medicare paid providers under fee-for-service (FFS) for services furnished to beneficiaries enrolled in risk-based health maintenance organizations (HMO). Our review included beneficiaries residing in Colorado, Florida, Missouri, and Pennsylvania who were enrolled in a risk plan for at least 1 month during Calendar Years 1995 through 1997. Our audit was limited to FFS Part A only.

We found that the Medicare fiscal intermediaries improperly paid \$2.3 million for FFS Part A services provided to the beneficiaries enrolled in risk-based HMOs. Because Medicare paid HMOs to provide all medically necessary services for these beneficiaries, payments under FFS were duplicate payments. The \$2.3 million in duplicate payments consisted of 733 claims in 4 States.

- ▶ For 562 claims, totaling \$1.6 million, we determined that the HMO enrollment status was submitted and recorded on the Health Care Financing Administration's (HCFA) systems prior to payment. These claims should have been identified as HMO claims during the fiscal intermediaries prepayment edit process.
- ▶ For 171 claims, totaling \$700,000, we noted that a duplicate FFS payment occurred because of beneficiaries' retroactive enrollments in an HMO. The HCFA developed a process to recoup duplicate payments made during retroactive periods, but did not use this process.

Although we did not review potential duplicate FFS payments beyond the four States, we believe that improper payments are being made nationally since procedures to detect and prevent these duplicate payments have not been implemented. We also believe the amount of duplicate payments could be significant when considering the HMO risk plan enrollees in the States not reviewed and the fact that Medicare FFS Part B services were not reviewed as part of this audit.

Compounding the problem of duplicate FFS payments is the impact these duplicate payments have on future HMO payments. The Balanced Budget Act of 1997 links the 1998 and future HMO capitation rates to the 1997 Medicare FFS expenditures. The law does not allow for any adjustments to this base. Because HMO capitation rates are based on actual FFS expenditures, the types of duplicate payments identified in this report will cause future rates for HMOs to be inflated.

We previously reported to HCFA that legislation should be introduced to adjust the 1997 base year HMO rates for payment errors. In September 1998, we issued a report entitled "Capitation Rates For Medicare Managed Care Plans Are Inflated Due To Improper Payments Included in the Rate Calculations" (A-14-97-00206) which addressed the payment errors detected in our audits of HCFA's 1996 and 1997 financial statements. The payment errors identified in the financial statement audits related mostly to instances of inadequate documentation, lack of medical necessity, incorrect coding, and noncovered or unallowable services. Even though the duplicate payment amounts found in this review are substantially less than the financial statement findings, it is another example showing that adjustments to the 1997 base HMO rate are justified.

We recommended that HCFA: (i) strengthen procedures to prevent and detect duplicate payments where the HMO has payment responsibility, (ii) identify and recoup all duplicate FFS payments made under Medicare Parts A and B for HMO enrollees, including the \$2.3 million identified in this report, and (iii) consider developing a legislative proposal to adjust the HMO capitation rates for the duplicate payments that were included in the managed care rate calculation methodology.

In response to our draft report, HCFA concurred with our recommendation to strengthen procedures to prevent and detect duplicate payments as well as our recommendation to identify and recoup all duplicate FFS payments. However, HCFA did not believe it was advisable at this time to seek the authority from Congress to adjust the HMO capitation rates for the duplicate payments that were included in the managed care rate calculation methodology.

We believe HCFA should take the necessary steps to revise the 1997 base HMO rates and remove known errors. Continuing to include the improper payments in the base rates will result in perpetual overpayments to HMOs. We would appreciate your views and the status of any action taken or contemplated on our recommendation within the next 60 days. Any questions or further comments on any aspect of the report are welcome. Please address questions or comments to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-07-97-01247 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF FEE-FOR-SERVICE
PAYMENTS FOR SELECTED MEDICARE
BENEFICIARIES ENROLLED IN
MANAGED CARE RISK PLANS**



JUNE GIBBS BROWN
Inspector General

OCTOBER 1999
A-07-97-01247

**Memorandum**

Date OCT 27 1999

From June Gibbs Brown
Inspector General *June G Brown*

Subject Review of Fee-For-Service Payments for Selected Medicare Beneficiaries Enrolled in
Managed Care Risk Plans (A-07-97-01247)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report provides you with the results of our audit of Medicare fee-for-service (FFS) payments to providers for beneficiaries enrolled in risk-based managed care plans, commonly referred to as health maintenance organizations (HMO). We found, in four States, that the Medicare fiscal intermediaries improperly paid \$2.3 million for Part A services provided to beneficiaries enrolled in risk-based HMOs. These Part A services were furnished during Calendar Years (CY) 1995 through 1997. Because Medicare paid HMOs to provide all medically necessary services for these beneficiaries, payments under FFS were duplicate payments. Although we did not review potential duplicate FFS payments beyond the four States, we believe that improper payments are being made nationally since the Health Care Financing Administration (HCFA) has not implemented procedures to detect and prevent these duplicate payments.

We recommended that HCFA: (i) strengthen procedures to prevent and detect duplicate payments where the HMO has payment responsibility, (ii) identify and recoup all duplicate FFS payments made under Medicare Parts A and B for HMO enrollees, including the \$2.3 million identified in this report, and (iii) consider developing a legislative proposal to adjust the HMO capitation rates for the duplicate payments that were included in the managed care rate calculation methodology.

In response to our draft report, HCFA concurred with our recommendation to strengthen procedures to prevent and detect duplicate payments as well as our recommendation to identify and recoup all duplicate FFS payments. However, HCFA did not believe it was advisable at this time to seek the authority from Congress to adjust the HMO capitation rates for the duplicate payments that were included in the managed care rate calculation methodology.

BACKGROUND

Managed care is defined as a health delivery and payment structure in which the payer organization seeks to control costs and maintain uniform quality of care by exercising specific controls over treatment and fees

charged by participating providers. Managed care concepts have helped private sector payers contain health care costs and limit excess utilization. The Congress, recognizing the potential cost-control advantages, enacted legislation to incorporate managed care options into the Medicare program. Since 1985, beneficiaries have had the option of enrolling in risk-based HMOs.

Under Medicare risk-based contracts, HMOs receive a capitated payment every month for each of their enrollees. With these capitations, HMOs must arrange and pay for all medically necessary services. Under the HMOs lock-in provision, beneficiaries are required to use the HMOs' physicians, hospitals, and affiliated providers. Payment for services from providers outside the HMO's network are the responsibility of the enrollee, not Medicare or the HMO (the HMO is responsible for out of network emergency services and services denied and later approved upon appeal).

SCOPE

We performed our audit in accordance with generally accepted Government auditing standards. Our objective was to determine if Medicare paid providers under FFS for services furnished to beneficiaries enrolled in HMOs.

Our audit included beneficiaries residing in Colorado, Florida, Missouri, and Pennsylvania who were enrolled in a risk plan for at least 1 month during CYs 1995 through 1997. These beneficiaries represented approximately 25 percent of all Medicare risk enrollees. We reviewed Part A payments to inpatient, skilled nursing facility (SNF), and home health agency (HHA) providers. We did not review internal controls for any of the payment mechanisms. Our audit was performed at OAS offices in Baltimore, Maryland and Kansas City, Missouri.

We used data from the Standard Analytical Files and the Common Working File. To determine when beneficiaries were enrolled in Medicare HMOs, we accessed the Enrollment Database (EDB) and the Managed Care Option Information System. We reviewed Medicare Part A claims paid by intermediaries on a FFS basis when either the EDB (1995 and 1996 claims) or the Group Health Plan database (1997 claims) showed the beneficiary was enrolled in an HMO.

RESULTS OF REVIEW

The Medicare fiscal intermediaries improperly paid \$2.3 million for Part A services provided to beneficiaries enrolled in risk-based HMOs. These services were furnished during CYs 1995 through 1997 for beneficiaries residing in the four States we reviewed. Because Medicare paid HMOs to provide all

medically necessary services for these beneficiaries, payments under FFS were duplicate payments. We recommended that HCFA: (i) strengthen procedures to prevent and detect duplicate payments where the HMO has payment responsibility, (ii) identify and recoup all duplicate FFS payments made under Medicare Parts A and B for HMO enrollees, including the \$2.3 million identified in this report, and (iii) introduce legislation to adjust the HMO capitation

rates for the duplicate payments that were included in the managed care rate calculation methodology.

CLAIMS PROCESSING

The HCFA administers Medicare largely through an administrative structure of claims processing contractors. Generally, fiscal intermediaries are the contractors that handle Part A claims submitted by 'institutional providers' (hospitals, SNFs, hospices, and HHAs); carriers handle Part B claims submitted by physicians, laboratories, equipment suppliers, and other practitioners.

After receiving claims from providers, intermediaries query HCFA's system to determine the beneficiary's HMO status. For beneficiaries enrolled in risk-based HMOs, the intermediary processes the bill showing "*HMO payment*" and "*... zeros as Medicare Reimbursement Amount.*" The Part A Intermediary Manual instructs: "*Do not make a duplicate payment for the same services the HMO has paid.*"

PAYMENT RESPONSIBILITY

For inpatient claims, the beneficiary's HMO status at admission determines whether the HMO or the intermediary has payment responsibility. Intermediaries have payment responsibility for claims of patients admitted into a hospital before the effective date of HMO enrollment. Likewise, HMOs have payment responsibility for claims of patients admitted into a hospital on or after the effective date of HMO enrollment, regardless of the disenrollment date. The hospital discharge date is not a determining factor.

However, the following are exceptions to the above:

- ▶ For services furnished at non-prospective payment system (PPS) hospitals or units, SNFs, and HHAs, the Part A Intermediary Manual states "*... the HMO is responsible for payment for services on and after the day of enrollment through the day disenrollment is effective.*"
- ▶ An HMO can be reimbursed on an FFS basis for those enrollees who have elected hospice coverage. Services directly related to the terminal condition are provided by and paid to a Medicare certified hospice, not the HMO. The HMO Manual states the managed care plan is "*... responsible for providing any Medicare covered services not related to the terminal condition, and ... are paid by HCFA on a fee-for-service basis.*" Upon hospice election, HCFA either suspends or reduces the Medicare capitation payment made to the HMO for that beneficiary. If the beneficiary revokes the hospice election, the HMO should "*... bill fee-for-service for all covered services furnished from the date of revocation until the full monthly capitation payment begins again on the first day of the following month.*"

- ▶ Prior to 1996, HCFA designated lung and heart-lung transplants as national coverage determinations. Because the costs associated with these determinations had not been used in the capitation rate calculations, HCFA did not require HMOs to absorb the costs of providing the services. Thus, HCFA reimbursed HMOs for these services on an FFS basis, until they were included in the 1996 capitation rate calculations.

IMPROPER FFS PAYMENTS

To determine if duplicate payments were made, we reviewed Medicare paid claims for HMO beneficiaries enrolled in four States. We classified claims as duplicate payments if the first day of the provider's billing statement occurred while the beneficiary was enrolled in a Medicare managed care risk plan. For those inpatient, HHA, and SNF claims which were not subject to PPS, the claim also had to end before the disenrollment date. We eliminated services involving hospice elections and those heart and lung transplants occurring in 1995, because they were allowable under FFS for HMO beneficiaries. Using this criteria, we identified \$2.3 million in duplicate payments, which consisted of 733 claims.

Our audit was limited to 25 percent of risk enrollees and their related Medicare Part A services. We believe the amount of duplicate payments could be significant when considering the 75 percent of risk enrollees not reviewed and Medicare Part B services.

HMO STATUS ESTABLISHED

For 562 claims, totaling \$1.6 million, we determined that the HMO enrollment status was submitted and recorded on HCFA's systems prior to payment. We could not determine why the duplicate payments occurred. Additionally, we do not know why the payments were not later detected and corrected. These claims should have been identified as HMO claims during the fiscal intermediaries prepayment edit process.

RETROACTIVE ENROLLMENTS

For 171 claims, totaling \$700,000, we noted that a duplicate FFS payment occurred because of beneficiaries' retroactive enrollments. The HMO enrollment data is normally submitted to HCFA prior to the effective enrollment date; however, retroactive adjustments occur when HCFA receives the data after the effective date. When plans request a retroactive enrollment, HCFA stated its policy was to identify and verify that no FFS claims were paid during the retroactive enrollment period. The HCFA developed a process to recoup duplicate payments made during retroactive periods, but did not use this process for at least 2 years.

HMO PAYMENT CALCULATION

The computation of HMO capitation rates is linked to actual Medicare FFS expenditures. The Balanced Budget Act (BBA) of 1997 revised the payment calculation methodology for HMOs

effective January 1998. The payment rate is now the greater of a blended capitation rate, a minimum amount rate, or a two percent annual increase. However, the new methodology is still linked to Medicare FFS expenditures. The calculation uses as a base the 1997 county-specific adjusted average per capita cost rates which were based on FFS expenditures. The law does not stipulate any adjustments to this base other than to carve out a specified portion of the rates which are for medical education expenses. The 1997 rates will be updated by the national average per capita increase in Medicare FFS expenditures minus a percentage specified in the law. Several other calculations will be performed on the base rates to blend the rates between HMO local area payment rates and an overall national HMO average payment rate. This blending is designed to reduce the current wide geographic variations in payment rates. The methodology for years after 1998 is essentially the same with various adjustment percentages specified in the law. In addition, beginning with the rates for 1999, adjustments will be made to compensate for differences between actual and estimated Medicare growth rates used in the 1998 and later calculations. The actual capitation payment rate to the HMOs is still adjusted for each beneficiary's demographic characteristics; i.e., age, gender, Medicaid eligibility, and other special characteristics. Starting in the year 2000, the BBA of 1997 will require a payment adjustment for beneficiary health status factors.

Because HMO capitation rates are based on actual FFS expenditures, the types of duplicate payments identified in this report will cause future rates for HMOs to be inflated. Unless the duplicate FFS payments are removed from capitation rate calculations, they will continue to result in the equivalent of an overpayment in the Medicare managed care program at the expense of the Medicare trust funds. The effects of the inflated capitation rates will be magnified as total payments to HMOs increase due to increased enrollment. Removing the duplicate FFS payments from capitation rate calculations would reduce inappropriate expenditures from the financially troubled trust funds as well as help reduce the inequities of excessive HMO payment rates.

RECOMMENDATIONS

We recommended that HCFA:

1. Strengthen procedures to prevent and detect duplicate payments where the HMO has payment responsibility,
2. Identify and recoup all FFS payments (Medicare Part A and Part B) for beneficiaries enrolled in HMOs, including the \$2.3 million identified in this report, and

3. Consider developing a legislative proposal that will allow modifications to HMO capitation rates which would include an adjustment for the estimated amounts of improper payments that are included in managed care organization rate calculations.

HCFA COMMENTS

The HCFA agreed to strengthen procedures to prevent and detect duplicate payments where the HMO has payment responsibility. Previous efforts were limited to specific populations and also hampered by systems problems. The HCFA anticipates completing programming steps in the next several months that will detect duplicate payments for all FFS payments made during a managed care enrollment period. The HCFA also agreed to identify and recoup all duplicate FFS payments retroactively to 1996 or as far back as legally possible.

The HCFA did not concur with our recommendation to allow modifications to HMO capitation rates which would include an adjustment for the estimated amounts of improper payments that are included in managed care organization rate calculations. Since the BBA, HCFA has advised Congress that the 1997 rates are overstated by about four percent. Because Congress has shown no interest in addressing this issue, HCFA believes it would not be beneficial to raise the issue of another significantly smaller overpayment. The complete text of HCFA's response is presented as Attachment A to this report.

OIG RESPONSE

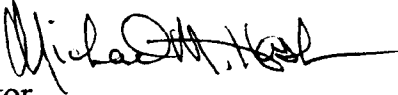
We look forward to HCFA's enhancements to the claims processing systems to detect all duplicate payments for all FFS payments made during a managed care enrollment period. Under separate cover, we will provide HCFA with a list of all claims identified in this report paid by Medicare for beneficiaries enrolled in a risk plan.

We believe HCFA should take the necessary steps to enable it to revise the 1997 base HMO rates and remove known errors. Continuing to include the improper payments in the base rates will result in perpetual overpayments to HMOs. We look forward to working with HCFA in further analysis of managed care issues. This final report has been revised to reflect HCFA's technical comments.

Deputy Administrator
Washington, D.C. 20201

DATE: JUL 28 1999

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash 
Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Fee-For-Service Payments for Selected Medicare Beneficiaries Enrolled in Managed Care Risk Plans," (A-07-97-01247)

We appreciate the opportunity to review the subject draft report. The report found that Medicare fiscal intermediaries (FIs) inappropriately paid for Part A services provided to beneficiaries enrolled in risk-based HMOs in four states. Because Medicare paid HMOs for services rendered to these beneficiaries, payments made under FFS were duplicate payments.

Some, but not all duplicate payments are occurring because the Health Care Financing Administration's (HCFA's) Common Working File (CWF) is not updated with managed care enrollment data for a period of 2 to 3 months. During this delay, claims are being processed through FFS during a managed care enrollment period that has not yet been updated on the fiscal intermediary's files. As was mentioned in the report, this can also occur if a retroactive enrollment is approved and entered into the system by a regional office staff member. However, the regional office staff are instructed to view CWF and ensure no FFS payments have been made during the time of the requested enrollment before processing the retroactive enrollment date.

The report indicated that the HCFA had a duplicate payment process in place but did not implement it. However, the Medicare managed care program only had a duplicate payment recoupment process that had been implemented in conjunction with legislation that allowed managed care organizations to submit retroactive enrollments for some of their employer group members. This recoupment process was used for several years on retroactive employer group enrollments only, but more recently systems problems have prevented this duplicate payment recoupment process from being utilized. The programming required to correct the recoupment process has been initiated. It is under implementation with anticipated completion in the next several months.

Page 2 - June Gibbs Brown

Enhancements to the claims processing systems have enabled us to add requirements to the recoupment process which now enables the program to detect duplicate payments for all FFS payments made during a managed care enrollment period.

Our specific comments follow:

OIG Recommendation

HCFA should strengthen procedures to prevent and detect duplicate payments where the Health Maintenance Organization has payment responsibility.

HCFA Response

We concur and are implementing procedures to address this recommendation. Enhancements to the claims processing systems, expected to be implemented in October 1999, will enable us to detect duplicate payments for all FFS payments made during a managed care enrollment period. We are developing a Beneficiary Database which we plan to prototype by April 2000. The Beneficiary Database will contain beneficiary specific information including Managed Care enrollment periods. If the prototype of the Beneficiary Database is successful, we will be able to develop appropriate interfaces with the Group Health Plan system and subsequently the claims processing systems, which will correct the 2 to 3 month delay in update of enrollment to CWF. The claims processing systems will know immediately of the change to enrollment. In addition, by May 2002, a redesigned enrollment process will be implemented to process enrollments as they are received, instead of on a monthly basis. Although retroactive enrollments will still exist, the new enrollment process should reduce the number of retroactive enrollments, as well as create a more timely update of enrollment information for the claims processing systems to use for verifying enrollments and preventing duplicate payments.

OIG Recommendation

HCFA should identify and recoup all duplicate FFS payments (Medicare Part A and Part B) for beneficiaries enrolled in HMOs, including the \$2.3 million identified in this report.

HCFA Response

We concur. Where a definite determination has been made that a claim was paid improperly, we will actively pursue recovery of all duplicate payments retroactively to 1996 or as far back as legally possible. The recoupment process has been modified to identify overpayments for all Managed Care Plans and is expected to run on an on-going production basis beginning in August 1999. The identified overpayments will be sent on an ongoing basis to the regions to initiate the recoupment of payment through the carrier.

Page 3 - June Gibbs Brown

OIG Recommendation

HCFA should pursue legislation that will allow modifications to HMO capitation rates which would include an adjustment for the estimated amounts of improper payments that are included in managed care organization rate calculations such as this report outlines as well as the audit results reported in our prior referenced audit report A-14-97-00206.

HCFA Response

We do not believe it is advisable at this time for the Administration to seek the authority from Congress to make the change outlined in the report.

The Balanced Budget Act of 1997 (BBA) established the 1997 ratebook as the base for future Medicare+Choice capitation rates and broke the prior link between Medicare capitation rates and local fee-for-service costs. Since the enactment of the BBA, we have advised the Congress that more complete data, received since the 1997 rates were computed in 1996, indicate that the 1997 rates are overstated by about 4 percent. However, the Congress has shown no interest in amending the statute to address this significant overstatement. Until the Congress is willing to address this larger overpayment, it would not appear beneficial to raise another significantly smaller overpayment.

In addition, it is quite possible that the practice of duplicate billing is or was more prevalent in some counties than in others. Without complete and accurate data to compute county-specific reductions, we could only propose an across the board reduction which would not be equitable.

Technical Comments

The report indicates that HCFA should "introduce" legislation to adjust the capitation rates. HCFA is not in a position to directly introduce legislation. Rather, HCFA can forward legislative proposals that would have to be reviewed and approved by the Department and the Office of Management and Budget before being forwarded by the Administration to the Congress as part of the annual budget submission. Similarly, the report indicates on page 5 that "HCFA needs to correct the errors that were included in the 1997 base HMO rates." Without a change to the law, HCFA can not change the base, regardless of the nature or source of any over- or under-statements in that base.